PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This recertification survey was conducted on April 14, 2008 through April 17, 2008. The survey was initiated utilizing the fundamental survey process. A random sampling of two clients from the residential population of four clients with varying degrees of disabilities was identified. The findings of this survey were based on observations at the group home and two day programs, interviews with day program staff and residential staff, the review of clinical and administrative records and the review of the facility's unusual incident reports.	W 000		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to ensure privacy during the administration of medications was provided for two of the four clients residing in the facility. (Clients #1 and #4) The finding includes: On April 17, 2008 at 6:58 AM the Registered Nurse (RN) was observed to administer Client #4 his medication while he was eating breakfast at the table with Clients #1 and #3. At 7:02 AM, the RN was observed to administer Client #1 his medication while he was eating breakfast at the table with Client #4. Interview with the Supervisory RN revealed that it was the facility's practice to promote privacy during medical	W 130	W130 It is the policy of My Own Place Inc. to ensure the privacy of each resident at all times. (See attached Policy on Medication Delivery) Subsequently the RN who administered the medication was counseled and re-trained on protecting individual rights during the delivery of medication. She will be monitored by the supervising RN for the next 90 days to ensure that she complies with guidelines set forth in the policy. Additionally, an in-service has been scheduled on May 22, 2008 to review our medication delivery system in an effort to ensure the rights of each individual, is safeguarded.	May 22, 2008 Ongoing

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 MAY 19 A 8:41

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Exec Director | (X6) DATE: 5/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 1 interventions. There was no evidence the identified clients was provided privacy during the administration of there morning medications.	W 130		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement its policy that ensured the client's health and safety, for one of two clients (Client #2) in the sample. The finding include: Cross refer to W153. The facility failed to ensure the timely reporting of an incident as documented in its "Incident Management" policy. The review of an unusual incident report dated 4/5/08 revealed staff discovered a scratch on Client #2's neck at 3:10 PM. The review incident report revealed that only the acting house manager and the nurse were notified of the client's injury at 4: 20 PM and 4:10 PM respectively. The corresponding addendum revealed the administrator's designee (Incident Management Coordinator) received notification of the incident on 4/7/08 at 1:00 PM. Notification was faxed to the Department of Health (DOH) on 4/7/08 at 3:44 PM. The review of the facility's incident management policy revealed the following steps should occur after an incident: a) Staff should immediately notify the Qualified	W 149	W149 A. The QMRP was notified verbally of the incident however it was not noted on the notification page of the incident report. Staff will be in-serviced on May 22, 2008 as to the policy for reporting all incidents to ensure effective and timely reporting. In the future this policy will be reviewed with staff on a quarterly basis.	May 22,2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 2 Mental Retardation Professional (QMRP). b) The QMRP should immediately notify the Incident management Coordinator and the Department of Health. There was no evidence the facility's QMRP was notified. Additionally there was no evidence that the incident management coordinator and DOH were notified timely in accordance with established policy.	W 149	B. The QMRP will be in-serviced on May 22, 2008 on the incident management policy to ensure effective and timely reporting of all incidents. In the future the incident management policy will be reviewed with the QMRP on a quarterly basis.	May 22,2008 and ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, were reported immediately to the administrator or to other officials in accordance with State law through established procedures for Client #2. The findings include: The facility failed to ensure Client #2's injury of unknown origin was reported timely to the Department of Health (DOH). a) The review unusual incidents on April 14, 2008 at 3:40 PM revealed on April 5, 2008 at 3:10 PM while riding in the van, staff discovered Client #2	W 153		

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 3 to have a red scratch which extended from below his right ear to the back of his neck. The incident report documented that Client #4 was the other client involved, however did not state how the client was involved. The incident report checklist revealed the client's injury was reported to the administrator's designee (incident management coordinator) on April 7, 2008 at 1:00 PM. The incident management coordinator questioned whether the incident was connected to Client #4 or if it was an injury of unknown origin. A transmittal dated 3:43 PM on April 7, 2008 indicated that the incident was reported to DOH at that time. There was no evidence that incident which may have been of unknown origin was reported timely to all required entities. b) According to a staff log note dated 4/5/08 (8:00 AM - 11:00 PM), "He (Client #2) was also hit at 3:20 PM by his peer..(Client #4). The progress note also indicated that while undressing the client at bath time, staff noticed another mark (a scratch) on the client's back (shoulder). There was also no evidence that incident of unknown origin was reported to DOH.	W 153	W153 A. It is My Own Place's policy that all incidents are reported to DOH within 24 hours. Unfortunately the Incident Management Coordinator was notified outside of the designated time however she immediately notified DOH. Staff, QMRP and Incident Management Coordinator will review the policy on reporting incidents including the timely notification to all outside agencies on May 22, 2008. B. The incident report and investigation was originally submitted on April 7, 2008 and re-submitted on April 18, 2008 (See attached). In the future all incidents will be reported in a timely manner as specified in the agency's policy. All staff will be in-serviced on the incident management policy and reporting of incidents on May 22, 2008.	May 22,2008 and ongoing April 18,2008 and ongoing
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Client #2's injury of origin was thoroughly investigated.	W 154		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 4 The finding includes: Cross Refer to W153. Interview with staff on April 14 2008 at 3:40 PM indicated that on April 5, 2008, Client #4 was seated beside Client #2 in the van and may have scratched him, however no one witnessed the scratching. The "Addendum to Incident Report" questioned if the incident was connected to Client #4 or if it was an injury of unknown origin. According to a staff log note dated 4/5/08 (8:00 AM), at 2:30 PM, staff noticed scratches on the right side of Client #3's neck. The progress note also indicated "he was also hit at 3:20 PM by his peer..(Client #4). The progress note also indicated that while undressing the client at bath time, staff noticed another mark (a scratch) on the client's back (shoulder). There was no evidence an comprehensive investigation was conducted to determine the origin of Client #2's injuries.	W 154	W154 The incident report and investigation was originally submitted on April 7, 2008 and re-submitted on April 18, 2008. After speaking with staff it was determined that they did not actually see client # 2 hit client #4. In the future all incidents will be thoroughly investigated and submitted to DOH within the allotted 5-day period in accordance with the incident management policy. Staff, QMRP, and incident management coordinator will be in-serviced on incident management policy on May 22, 2008 with subsequent reviews bi-annually.	May 22,2008 and ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for one client (Client #3) residing in the facility. The findings include:	W 159		

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 5 1. The QMRP failed to ensure that the proactive strategy identified in the behavior support plan to address Client #3's targeted behavior of hoarding was effectively implemented. [See W249] 2. The QMRP failed to ensure the consistent documentation of antecedents to Client #3's hoarding behavior. [See W252] 3. The QMRP failed to coordinate interventions to ensure they included a mechanism to teach and support appropriate behavior Client #3's hoarding behavior. [See W288]	W 159	W159 1. The QMRP in conjunction with the psychologist will in-service staff on proactive strategies to address client #3's hoarding behavior on May 22, 2008. In the future there will bi-annual trainings to review these strategies and ongoing training for staff as deemed necessary. 2. The QMRP in conjunction with the psychologist will in-service staff on documenting antecedents to address client #3's hoarding behavior on May 22, 2008. In the future there will bi-annual trainings to review these steps and ongoing training for staff as deemed necessary. Additionally, the QMRP will review BSP data weekly to ensure antecedents are consistently documented. 3. The QMRP will discuss with the psychologist and request modifications in BSP by May 22, 2008 to ensure mechanisms to teach, support and reinforce appropriate behaviors are identified in the plan and in-service training will then follow with ongoing observations ensuring consistent implementation.	May 22,2008 and ongoing May 22,2008 and ongoing May 22,2008 and ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record, the facility failed to ensure continuos training was provided to each employee to enable them to effectively and competently implement programs for three (Clients #1, #2, and #3) of the four clients residing in the facility. The finding includes: 1. The facility failed to ensure current training was effective on food textures. Staff training during the year was recommended by the nutritionist during the annual assessments for Clients # 1, #2, and #3. There was no evidence that staff had been trained on food textures. [See W474]	W 189	W189 1. An in-service is scheduled for May 22, 2008 with the nutritionist to review appropriate food textures for the individuals in the home. In the future this training will be conducted bi-annually or more frequently as changes occur	May 22,2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 6 2. The facility failed to ensure that each staff was effectively trained on menus substitutions. [See W481] 3. The facility failed to ensure that Trained Medication Employees were effectively trained on the agency' policy on medication errors. [See W331,3]	W 189	2. An in-service is scheduled for May 22, 2008 with the nutritionist to review appropriate food substitutions for the individuals in the home. In the future this training will be conducted bi-annually. 3. The RN will review the agency's policy on medication errors with all TME's on May 31, 2008 to ensure appropriate implementation of procedures. In the future this policy will be reviewed bi-annually. Additionally, the QMRP and QA consultant will conduct ongoing visits to the home to ensure staff implementation of all protocols.	May 22,2008 and ongoing May 31,2008 and ongoing
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on staff interviews and record verification, the facility staff failed to demonstrate competency in implementation the Behavior Support Plan (BSP) for one of four clients residing in the facility. (Client #3) The finding includes: The facility failed to ensure that each direct care staff was effectively trained on the implementation of Client #3's behavior support plan (BSP). [See W249]	W 193	W193 The QMRP in conjunction with the psychologist will in-service staff on the implementation of client #3's behavior support plan including proactive strategies, documenting antecedents, and employing mechanisms to teach them about the behaviors on May 22, 2008. In the future there will be bi-annual trainings to review these strategies as well as ongoing in house training sessions focusing on the specific needs of the individuals will continue to occur to provide opportunities for employees to be trained in order to effectively carry out their responsibilities.	May 22,2008 and ongoing
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that as soon as the interdisciplinary team formulated the individual program plan (IPP), continuous active treatment plan consisting of needed interventions to achieve identified objectives was provided for one (Client #3) of four clients residing in the facility. The finding includes: On April 14, 2008 at 7: 25 AM, Client #3 was observed ambulating using a rolling walker, which had a seat, with minimal difficulty. Interview with staff revealed the client was able to use his walker to ambulate to his bedroom and to the other necessary living areas in the facility. Staff indicated that Client #3 enjoyed the privacy that he was afforded by having his own bedroom, however he required supervision to ensure his safety and to prevent hoarding. Review of the Individual Support Plan on 4/14/08 revealed a goal to improve his behavior with a reduction in maladaptive incidents. The objective stated that the client "will reduce incidents of hoarding to 5 incidents or less for 12 consecutive months". According to the Behavior Support Plan (BSP) dated May 6, 2007, a proactive strategy for preventing hoarding was to ensure adequate monitoring by staff. The functional analysis in the BSP indicated that whenever the client tried to slip into his peers' room to get a their toothbrush	W 249	W249 The QMRP in conjunction with the psychologist will in-service staff on proactive strategies to address client #3's hoarding behavior on May 22, 2008. In the future there will be bi-annual trainings to review these strategies as well as ongoing training for staff as deemed necessary. Additionally, the QMRP and Residence Manager will conduct weekly environmental checks to ensure staff are implementing the BSP and monitoring appropriately and adequately.	May 22,2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST. NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 8 staff had been able to reason with him and instructed him to return the items. On April 15, 2008, several brushes were observed on the client's night stand. Interview with the direct care staff revealed that several of the brushes did not belong to the client. On the next day, April 16, 2008, staff discovered that the client had toothbrushes and a variety of lotions in his closet that did not belong to him. There was no evidence that the proactive strategy identified in the plan to address this targeted behavior had been effectively implemented.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure data relative to the accomplishment of the behavioral program objective was documented in measurable terms for Client #3. The finding includes: During observation of the environment on April 15, 2008, Client #3 was noted to have several hair brushes in his personal supplies. Interview with staff indicate that he may have obtained one of the brushes from another individual. Further interview with staff indicated that the client had a behavior support plan (BSP) which addressed hoarding.	W 252	W252 The QMRP in conjunction with the psychologist will in-service staff on documenting antecedents to address client #3's hoarding behavior on May 22, 2008. In the future there will be bi-annual trainings to review these steps as well as ongoing training for staff as deemed necessary. Additionally, weeklymonitoring of the data will continue with emphasis on reviewing the antecedents to ensure proper documentation.	May 22,2008 and ongoing

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 9 On April 17, 2008 staff indicated that the client was observed to have toothbrushes and a variety of lotions in his closet that did not belong to him on April 16, 2008. Interview with staff on April 15, 2008 revealed that Client #3 did not have a roommate. According to the BSP,whenever the client tries to slip into his peer's room in order to help himself to the peer's toothbrush, staff are able to reason with him and instruct him to return it because it does not belong to him. Review of the BSP dated May 6, 2007 revealed a goal "will reduce incidents of hoarding to 5 or less per month for 12 consecutive months". Instructions for data collection revealed "All incidents of target behavior should be documented on " the provided data collection sheets. When recording the data staff should indicate any possible antecedents, in detail, define the behavior, specify all staff interventions. There was no evidence the possible antecedents to the aforementioned targeted behavior were documented.	W 252		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on interview with direct care staff and record review, the facility failed to ensure that interventions used were related to an active treatment program to manage inappropriate behavior for one of four clients residing in the facility (Client #3).	W 288	W288 As of May 26, 2008 the psychologist will work with client #3 and staff monthly on strategies for reducing the frequency of the targeted behaviors. Additionally the BSP will be modified to identify strategies for teaching the individual alternative was to control or redirect his impulse to hoard.	May 26,2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 288	Continued From page 10 The finding includes: The facility failed to ensure the behavior support plan (BSP) included teaching strategies to prevent Client #1's hoarding of paper. Observation of the bathroom on the main level of the facility on April 14 and April 15, 2008 revealed no paper towel for drying of hands. Interview with the residential manager revealed that Client #3 put excessive toilet tissue in the commode which caused it to overflow. Interview with the residential manager on April 17, 2008 indicated that the client was able to use the bathroom independently, but was monitored every 5 to 7 minutes. The manager further indicated that to prevent Client #3 from putting excess paper in the commode, the toilet tissue was removed when he went into the bathroom and the paper towel was kept in the cabinet underneath the bathroom sink. The review of the clients Individual Support Plan (ISP) revealed a goal to improve his behavior with a reduction in maladaptive incidents. According to the May 6, 2007 Behavior Support Plan (BSP) functional analysis, "when presented with an opportunity (inadequate monitoring by staff), the client will gain access to items he usually likes to hoard, namely tissues and toilet paper." The individual program plan (IPP) objective stated that the client "will reduce incidents of hoarding to 5 incidents or less for 12 consecutive months". Although the functional analysis in the BSP identified hoarding of such items as toilet/tissue/napkin paper, it failed to identify strategies for teaching the client to reduce his frequency of this targeted behavior.	W 288		
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 11 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for three of the four clients residing in the facility. (Clients #1, #2 and #3) The findings include: 1. On April 14, 2008 at 6:15 PM, Client #4 was observed to be administered Haldol 15 mg by the Director of Nursing (DON). The nurse indicated that the monthly cycle of the medications would end with the evening medications on April 15, 2008. Interview with the nurse indicated that client was admitted to the group home on March 27, 2008 due to the closure of his previous group home. The review of the transfer medical order revealed that Client #4's medications included Haldol 15 mg BID. Further review of the MAR revealed the client continued to be prescribed this dosage of the medication. On April 17, 2008 at 6:58 AM, the facility Registered Nurse (RN) was observed administering Client #4 his morning medications. The review of the MAR revealed the client's dosage of Haldol had increased to Haldol on April 16, 2008 from 15 mg to 20 mg in the twice daily. Interview with the RN and the review of the physician's orders dated April 1, 2008 revealed the dosage was in accordance with the	W 322	W322 There were some inconsistencies with client #4's information upon his transfer to the facility. The error has since been corrected by the physicianand psychiatrist. Client #4 is currently receiving 15mg of Haldol twice daily to be reviewed and monitored by the PCP and psychiatrist monthly. Additionally, the medical director, Director of Health Services, and the RN will carefully review records of all new persons admitted to the program and resolve inconsistencies in information to provide proper preventative care.	April 17,2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 12 physician's orders. Further interview with the direct care staff, the facility's primary RN and the Director of Nursing failed to indicate a reason for the increase in the medication. The review of documented behaviors failed to reflect a reason for the medication increase. There was no evidence in the records (psychological, psychiatric, nursing or medical notes) to justify the need for the medication increase. 2 . The facility failed to ensure Client #3 received timely follow-up care for cataracts. Record review revealed a blank consultation form for ophthalmology dated 1/14/08. Interview with the staff indicated that the client did not go to the ophthalmology appointment as scheduled. Interview with the residential manager on April 15, 2008 at 2:00 PM revealed that another appointment had been scheduled for April 23, 2008. Interview with the R.N. and further record review on April 17, 2008 revealed the last available report of a completed ophthalmology examination was dated 7/19/05. During that consultation the client was diagnosed with early cataracts of both eyes. Annual follow-up had been recommended. At the time of the survey, there was no evidence the client had been monitored timely as recommended to determine the status of his cataracts. 3. The facility failed to ensure that Clients #1 and #2 received timely treatment services. [See W356.]	W 322	W322 2. Client #3 did complete his Ophthalmology appointment on April 23, 2008 as scheduled. On April 28, 2008 the nurse, home manager, and QMRP reviewed each medical book to ensure all follow-up appointments and treatments were scheduled and carried out for the individuals residing in the home. In the future the nurse, QMRP, and home manager will continue to meet monthly to review medical records and ensure that all medical appointments are completed in a timely manner. 3. On April 28, 2008 the nurse, home manager, and QMRP reviewed each medical book to ensure all follow-up appointments and treatments were scheduled and carried out for all individuals residing in the home. In the future the nurse, QMRP and home manager will continue to meet monthly to review medical records and ensure that all medical appointments are completed in a timely manner.	April 23,2008 and ongoing April 28,2008 and ongoing
W 331	483.460(c) NURSING SERVICES	W 331		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 13 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with the needs of four (Clients #1, #2, #3, #4) of four clients residing in the facility. The findings include: 1. The facility's nursing services failed to ensure timely follow-up with the primary care physician on Client #4's increase in his psychotropic medication. [See W322,3] 2. The facility's nursing services failed to ensure oversight of Trained Medication Employees (TMEs) to ensure policy on medication administration was implemented. The review of an unusual incident report dated February 16, 2008 on April 14, 2008 revealed that Client #1 was administered his prescribed MVI (multivitamin) two times in the morning. Interview with the Director of Nursing revealed that the medication nurse had already administered the medication when TME #2 entered the facility administered the client a second MVI in error. According to the medication policy, the TME should only administer medication upon approval by the nurse. The nurse also indicated that all persons administering medication should check the medication card to ensure that the medication was still available for the current date. At the time	W 331	W331 1. The nursing staff did immediately notify the physician of client #4's increase in psychotropic medication as soon as it was identified. The nursing staff will review drug regimens of each individual monthly as well as during the time of delivery to ensure appropriate and effective communication with the physician. 2. TME training will occur on May 30, 2008 to ensure established procedures are always implemented. The agency will continue to monitor and take necessary steps to correct improper practices as indicated in this situation to ensure oversight and compliance.	April 17,2008 and ongoing May 30,2008 and ongoing

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 14 of the survey, there was no evidence effective training had been provided to the TME to ensure established procedure for prevention of medication errors was implemented. The facility identified the deficient practice and corrected the practice by suspending the TME practice until the TME was retrained and evaluated.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for two of two clients in the sample. (Clients #1 and #2) The findings include: 1. During the meal observations on April 14, and April 15, 2008, Client #1 was observed to eat his meals slowly. Interview with staff indicated that he did not have "a lot of teeth". Record review on April 16, 2008 at 6:35 PM revealed the client had his annual dental evaluation on July 18, 2007. The dentist diagnosed large deposits of plaque on the clients remaining 8 teeth. The client was recommended to return to the dentist for scaling and polishing of his remaining teeth. The dentist noted that the client would be called to schedule	W 356	W356 1. Prior Authorization for various dental procedures are obtained by the dental office. The home manager has been checking with the dental office monthly to see if prior authorization has been received and will now document efforts attempting to schedule in the specialist section of the medical book. The Dental office states that it will notify the home once prior authorization has been received. The nurse, QMRP, and residence manager will continue to meet monthly to review medical records and ensure that all medical appointments are completed in a timely manner and narrative evidence provided to the director of health and documented in the individual record when treatment dates are extended. Additionally attempts to locate alternative dentist will be investigated to meet treatment needs timely and provider will continue to work with Health Resources Partnership and Government to address this systemic concern.	Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 356	Continued From page 15 an appointment for treatment services after preauthorization was received from the funding source. Interview with the Qualified Mental Retardation Professional (QMRP) on April 15, 2008 revealed that the dentist had not rescheduled the client. There was no evidence the client had received the treatment recommended for the maintenance of his dental health. 2. During breakfast on April 14, 2008 at 7:10 AM, Client #2 was observed eating a ground diet. Interview with staff indicated the client required a ground diet because he was unable to chew regular textured foods well. Further interview staff indicated the client had "bad and missing teeth". Record review the following dental interventions for the client: a) 4/7/07 - Client went for dental evaluation; refused to be assessed. b) 4/30/007 - Client returned to the dentist; got out of the chair and refused treatment. The desensitization plan was implemented, but was not successful. c) 5/10/07 - Client was sedated; an examination was performed. Teeth # 26 and #27 were extracted. The dentist also indicated that teeth #21 and #22 needed to be extracted and recommended that the client return to the dentist on June 25, 2007 to have the teeth extracted. The residential manager indicated that the teeth were not extracted because the Medicaid approval was not provided in time to obtain permission from the client's authored	W 356	2. Prior Authorization for various dental procedures is obtained by the dental office. The residence manager has been checking with the dental office monthly to see if prior authorization has been received. The Dental office states that it will notify the home once prior authorization has been received. In the future the nurse, QMRP and home manager will continue to meet monthly to review medical records and ensure that all medical appointments are completed in a timely manner. (See response to W356 #1)	Ongoing

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 356	Continued From page 16 representative to extract the teeth. Record review revealed that the client went back to the dentist on 11/19/07 however refused to sit in the chair for treatment. The dentist indicated that authorization would be requested and that the client would be scheduled for and exam and dental cleaning during the next visit. At the time of the survey, there was no evidence the client received the recommended dental treatment services.	W 356		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure therapeutic diets addressed the nutritional needs of two (Clients #1 and #3) of the four clients residing in the facility. The finding includes: 1. The facility failed to ensure that Client #1's diet included 1500 calories as prescribed to promote weight loss. On April 14, 2008, Client #1 was observed to receive a snack of yoghurt and juice after returning home from his day treatment program. The Annual Nutritional Assessment dated 5/1/07 revealed the client was prescribed a 1500 calorie, low fat, low cholesterol, no salt diet. The nutritionist assessed the client's DBW range to be	W 460	W460 1. On May 13, 2008 the nutritionist did clarify her order regarding client #1 caloric intake. (see attached) The nutritionist will continue to monitor client #1's nutritional status on a quarterly basis ensuring that the appropriate documentation detailing progress is appropriately filed in the individual's book. Additionally, physician will indicate written follow-up in quarterly reports.	May 13, 2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 460	Continued From page 17 150 -183 for his height of 5 feet,10 inches. At that time, the client's weighed 216 pounds, which was 116% of his maximum desirable body weight (DBW). This reflected a weight gain of 8 pounds since the previous Individual Support Plan (ISP). The nutritionist recommended that the diet be implemented as written and that portions be measured to encourage weight loss on the 1500 calorie diet. A September 18, 2007 medical progress note indicated that Client #1 needed further calorie restriction to promote weight loss. The PCP recommended that the client have nutritional follow-up and recommendations. A January 22, 2008 physician's order for 32 oz of Gatorade/ Sports drink daily to supplement the 1500 calorie diet was also noted. On February 18, 2008 the PCP documented that the client primary issue was the client's weight and recommended that the client be provided only the diet as recommended by the nutritionist. A 1/31/08 nursing monthly progress note indicated that the weighed 213 pounds and had gained three pounds since 12/07. A 2/29/08 progress note revealed the client had gained another pound. the current physician's order (dated 3/3/08) revealed a diet of 1500 calorie, Low Fat, Low Cholesterol, No Salt and 32 ounces sports drink. Review of the menus and also record review failed to indicate if the prescribed 32 ounces of sports drink and the snacks provided to the client were included with or in addition to the 1500 calories. Although the client's record included follow-up quarterly nutrition summaries after the annual review, there was no evidence the physician	W 460		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 460	Continued From page 18 recommendations for follow-up on the calorie level of the diet had been addressed. 2. The facility failed to ensure that Client #3's 1500 calorie diet was provided as prescribed. On April 17, 2008 at 7:03 AM, Registered Nurse (RN) administered Client #3 a fingerstick to test his blood glucose level. Interview with the Registered Nurse (R.N.) indicated that the client received fingerstick to monitor his blood glucose. Observation at 7:08 AM and interview with the R.N. revealed that the client received Metformin to control his blood glucose level. Record review confirmed that the aforementioned interventions are implemented to address the client's diagnosis of diabetes. On April 17, 2008, the client received juice, waffles, rice krispies, syrup, margarine and 2% milk for breakfast. Interview with staff indicated the client received regular syrup instead of the diet syrup on the menu for the calorie restricted diets because none was available. The review of the client's current diet order revealed the client's had a current physician's order dated 1/18/08 for a 1500 calorie, low fat, low cholesterol, dental soft, no concentrated sweets diet order. There was no evidence the client was provided his therapeutic diet as prescribed. [See also W474]	W 460	2. An in-service is scheduled for May 22, 2008 with the nutritionist to review appropriate diets and implementation of diet regimens for each individual in the home. In the future this training will be conducted bi-annually or more frequently as changes occur. The QMRP & Residence Manager will monitor food purchases and monitor compliance weekly to ensure prescribed diets are followed. A snack list will also be developed by the nutritionist by May 30, 2008 and the sports drink for client #1 will be recorded on the MAR to ensure compliance with order.	May 22, 2008 and ongoing
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure each food was	W 474		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 474	Continued From page 19 provided in the prescribed texture for two (Clients #2 and #3) of the four clients residing in the facility. The findings include: 1. During breakfast on April 14, 2008 at 7:25 AM, Client #3 was observed to consume a ground textured meal of sausage, toast, grits, 2% milk. During dinner on April 14, 2008 at 7:10 PM Client #4 was observed to receive a chopped meal of baked fish, greens scalloped potatoes, which was later followed by chopped grapes for dessert. Staff was observed manually chopping the client's food. The client stirred all of his food together, began independently eating, and by 7:25 PM had completed his meal. Interview with staff indicated that he tolerated a chopped diet. The client's had a current physician's order dated 1/18/08 for a 1500 calorie, low fat, low cholesterol, dental soft, no concentrated sweets diet order. Review of the diet list dated April 2007 which the nutritionist provided which stated each client's diet order revealed instructions to provide Client #3 with a 1500 calorie diet, no concentrated sweets, low fat , low cholesterol, ground texture diet. Preparation instructions indicated that the food should be prepared in a food processor or blender and be moist and chunky, like ground meat or hash. There was no evidence Client #3 food was consistently provided in the texture prescribed by the physician. 2. On April 15, 2008 at 4:10 PM, Client #2 was observed to receive a snack of sliced banana. Staff attempted to replace the slice banana with chopped banana, however the client continued to hurriedly fill his mouth full of the sliced banana.	W 474	W474 1. The QMRP and RN will clarify diet order with the nutritionist and physician by May 19, 2008. An in-service is scheduled for May 22, 2008 with the nutritionist to review appropriate food textures for the individuals in the home. In the future this training will be conducted bi-annually or more frequently as changes occur. 2. An in-service is scheduled for May 22, 2008 with the nutritionist to review appropriate food textures for the individuals in the home. In the future this training will be conducted bi-annually or more frequently as changes occur. Additionally, the QMRP, RN and Residence Manager will monitor compliance of diet textures on an ongoing basis to ensure compliance and pictures of diet textures will be requested from the speech and language pathologist and posted on the refrigerator for staff to refer to.	May 22, 2008 and ongoing May 22, 2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 474	Continued From page 20 Interview with staff indicated that the client receives a ground diet because he has few teeth. Record review April 15, 2008 revealed the client's revised mealtime protocol (dated 2/2008) requires that he be provided a ground textured regular diet. There was no evidence the snack was provided at the prescribed texture.	W 474		
W 481	483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that menu substitutions were documented for four of four clients residing in the facility (Clients #1, #2, #3,and #4). The findings include: 1. Observation of the dinner meal on April 14, 2008 at 7:10 PM revealed the meal consisted of baked fish, mashed potatoes, green beans, and peaches and water. The review of the scheduled menu (Cycle 3, Thursday) revealed that baked fish, macaroni and cheese, stewed tomatoes, fruit cocktail, cornbread margarine, and beverage were on the printed menu. Interview with the staff indicated that if a food was not available, a food from the same food group was selected instead. Further interview with staff indicated that the food that was served in place of the item on the menu was documented on the food inventory form. Review of the food inventory form revealed that the last item was entered on January 17, 2008. Staff indicated that a more current inventory form showing recent menu	W 481	W481 An in-service is scheduled for May 22, 2008 with the nutritionist to review appropriate food substitutions and documentation of the substitutions as described in the agency's policy. In the future this training will be conducted bi-annually or more frequently as changes occur. Additionally, shopping lists will be developed weekly in accordance with the menu and existing food supply in home. Menu adherence will be emphasized in the May 22nd training and continued mealtime observations will be conducted by the QMRP, Residence Manager, and nutritionist. Furthermore the food inventory form will be discontinued and staff will document actual substitutions on daily menu as necessary.	May 22,2008 and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 481	Continued From page 21 changes should be available; however, it was not located during the survey. The review of the facility's policy on "Menu Substitutions - Guidelines and Information" revealed that after choosing a food to substitute for the one on the menu, the change would be written on the menu or on the menu substitution form. There was no evidence that the each menu listed all foods actually served for the last 30 days.	W 481		

PRINTED: 05/08/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS This relicensure survey was conducted on April 14, 2008 through April 17, 2008. The survey was initiated utilizing the fundamental survey process. A random sampling of two residents from the residential population of four residents with varying degrees of disabilities was identified. The findings of this survey were based on observations at the group home and two day programs, interviews with day program staff and residential staff, the review of clinical and administrative records and the review of the facility's unusual incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the interior and exterior of each GHMRP were maintained in a safe, clean, orderly, attractive, and sanitary manner. The findings include: The following environmental concerns were identified during the observations on April 17, 2008 at approximately 2:55 PM. 1. Heavily scaling paint was observed on the area underneath the edge of the roof at the right rear of the house.	I 090	1090 1. Maintenance repair of the scaling paint on the roof has been scheduled for June 6, 2008. In the future monthly maintenance checks will be completed, documented, and submitted to the maintenance department to ensure the facility is in good repair.	June 6,2008 and ongoing

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Executive Director (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 1 2. Four stained areas were observed on the ceiling of the large room located in the front section of the basement. Stains were also seen on the ceiling, near the shower of the basement bathroom. 3. The screen door at the basement exit was observed to be broken and the screen was detached at the bottom. Space was observed at the side and top of the interior basement door which was installed at the same exit door. 4. Broken tiles were observed on the floor of the laundry room. 5. Only one of the fluorescent light bulbs in the fixture in the utility room was operable, which caused the lighting in this area to be dim. The light fixture cover of the fluorescent light was also not secured tightly in place. 6. No paper towel or toilet paper holders were available in the basement bathroom. The lighting in this bathroom was also dim. 7. The right door hinge of the linen closet was not secured to the frame. 8. Soil was observed on the interior bottom of the kitchen cabinets. 9. The hinge was broken on the right lower cabinet door.	I 090	2. Maintenance repair of the stains in the ceiling has been scheduled for May 27, 2008. In the future monthly maintenance checks will be completed, documented, and submitted to the maintenance department to ensure the facility is in good repair. 3. Maintenance repair of the broken screen door in the basement has been scheduled for June 6, 2008. In the future monthly maintenance checks will be completed, documented, and submitted to the maintenance department to ensure the facility is in good repair. 4. Maintenance repair of the broken tiles in the basement has been scheduled for June 6, 2008. In the future monthly maintenance checks will be completed, documented, and submitted to the maintenance department to ensure the facility is in good repair. 5. A second fluorescent light bulb was added to the fixture in the utility room on April 17, 2008 and the fixture cover was tightened and secured. 6. A paper towel holder will be installed on May 27 and the lighting in the bathroom will also be corrected and improved at this time. In the future monthly maintenance checks will be completed, documented, and submitted to the maintenance department to ensure the facility is in good repair. 7. Maintenance repair of the right door hinge of the linen closet has been scheduled for May 27, 2008. In the future monthly maintenance checks will be completed, documented, and submitted to the maintenance department to ensure the facility is in good repair. 8. The soil on the interior bottom of the kitchen cabinets was removed on April 17, 2008. In the future monthly maintenance checks will be completed ensure the facility is in good repair. 9. Maintenance repair of the hinge on the right lower cabinet door has been scheduled for May27, 2008. In the future monthly maintenance checks will be completed, documented, and submitted to the maintenance department to ensure the facility is in good repair.	May 27,2008 and ongoing June 6, 2008 and ongoing June 6,2008 and ongoing April 17, 2008 and ongoing May 27,2008 and ongoing May 27,2008 and ongoing April 17, 2008 and ongoing May 27,2008 and ongoing
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other	I 379		

PRINTED: 05/08/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 2 unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day in accordance with the reporting requirement in 3519.5. The finding includes: The facilityfailed to ensure Resident #2's injury of unknown origin was reported timely to the Department of Health (DOH). a) The review unusual incidents on April 14, 2008 at 3:40 PM revealed on April 5, 2008 at 3:10 PM while riding in the van, staff discovered Resident #2 to have a red scratch which extended from below his right ear to the back of his neck. The incident report documented that Resident #4 was the other resident involved, however did not state how the resident was involved. The incident report checklist revealed the	I 379	1379 The Staff completed the incident of unknown origin for client #2 on May 14, 2008. In the future all incidents will be reported in a timely manner as specified in the agency's policy. All staff will be in-serviced on the incident management policy and reporting of incidents on May 22, 2008.	May 14, 2008 and ongoing

PRINTED: 05/08/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 3 resident's injury was reported to the administrator's designee (incident management coordinator) on April 7, 2008 at 1:00 PM. The incident management coordinator questioned whether the incident was connected to Resident #4 or if it was an injury of unknown origin. A transmittal dated 3:43 PM on April 7, 2008 indicated that the incident was reported to DOH at that time. There was no evidence that incident which may have been of unknown origin was reported timely to all required entities. b) According to a staff log note dated 4/5/08 (8:00 AM - 11:00 PM), "he (Resident #2) was also hit at 3:20 PM by his peer..(Resident #4). The progress note also indicated that while undressing the resident at bath time, staff noticed another mark (a scratch) on the resident's back (shoulder). There was no evidence that incident of unknown origin was reported to DOH.	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided for four of four residents residing in the facility (Residents #1,#2, #3 and #4) The findings include:	I 401	1401 The nurse, QMRP, and residence manager will meet on a monthly basis to review medical appointments, schedule follow-up appointments, identify developmental levels and needs of each resident, assess treatment services to prevent further decline and schedule in-services for staff on delivery and implementation of services as outlines in treatment plan.	April 28, and ongoing

PRINTED: 05/08/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 4 [See Federal Deficiency Report - Citations W322, W331, W356, W474 and W460.]	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habiljtation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide habilitation, training and assistance to residents in accordance with the Individual Habilitation Plan of one of four residents residing in the facility. (Residents #1 and #3) The findings include: 1. The GHMRP failed to ensure that as soon as the interdisciplinary team formulated the individual program plan (IPP), continuous active treatment plan consisting of needed interventions to achieve identified objectives was provided for Resident #3). [See Federal Deficiency Report - Citations W249] 2. The GHMRP failed to ensure data relative to the accomplishment of the behavioral program objective was documented in measurable terms for Resident #3. [See Federal Deficiency Report - Citation W252] 3. The GHMRP failed to ensure that interventions used were related to an active treatment program to manage inappropriate behavior for Resident #3). [See Federal Deficiency Report - Citation W288]	I 422	1422 1. The QMRP in conjunction with the psychologist will in-service staff on proactive strategies to address client #3's hoarding behavior on May 22, 2008. In the future there will be bi-annual trainings to review these strategies as well as ongoing training for staff as deemed necessary. Additionally, the QMRP and Residence Manager will conduct weekly environmental checks to ensure staff are implementing the BSP and monitoring appropriately and adequately. 2. The QMRP in conjunction with the psychologist will in-service staff on documenting antecedents to address client #3's hoarding behavior on May 22, 2008. In the future there will be bi-annual trainings to review these steps as well as ongoing training for staff as deemed necessary. Additionally, weekly monitoring of the data will continue with emphasis on reviewing the antecedents to ensure proper documentation. 3. As of May 26, 2008 the psychologist will work with client #3 and staff monthly on strategies for reducing the frequency of the targeted behaviors. Additionally the BSP will be modified to identify strategies for teaching the individual alternative was to control or redirect his impulse to hoard.	May 22, 2008 and ongoing May 22, 2008 and ongoing May 26, 2008 and ongoing

PRINTED: 05/08/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G116	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	121 TUCKERMAN ST, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 5	I 500		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on on observation, interview and record review, the GHMRP failed to ensure that the rights of each resident were protected. The findings include: See Federal Deficiency Report - Citation W130, W149, W153, W154, W249, W322, W356, W331, W474 and W460.	I 500	1500 The residence director will ensure that the rights of all residents are observed and protected in accordance with DC Law 2-137 by reviewing and updating policies on Medication Delivery, Incident Management, Active Treatment, and Coordination and delivery of services by May 30, 2008. The residence director will ensure that all management staff have been appropriately trained on policies and monitor subsequent staff trainings as they are completed monthly.	May 30, 2008 and ongoing